TEXAS
Health and Human Services

Form 3064
January 2020-E

County Indigent Health Care Program (CIHCP)

Application for Health Care Assistance

For Office Use Only				
Status ◯ Application ◯ Review	Date Form 3064 Requested/Issued	Date Identifiable Form 3064 Received	Case Record No.	Appointment Date and Time, if applicable

Name (Last, First, Middle)	Home Area Code and Phone No.	Other Area Code and Phone No.

Have you ever used another name? If so, list other names you have used.
◯ Yes ◯ No

Mailing Address (Street or P.O. Box)	Apt. No.	City	State	ZIP Code

Home Address, if different from above. If it is rural, give directions.

1. On the chart below, fill in the first line with information about yourself. Fill in the remaining lines for everyone who lives in the house with you, whether or not you consider them household members.

Name (Last, First, Middle)	**Social Security No.** (if available)	**Sex** (Male/ Female)	**Date of Birth**	**Relation to You**	**Are you a sponsored alien?**
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No

Note: The word "household" in Questions 2 through 16 refers to you, your spouse and anyone else who lives with you and with whom you have a legal relationship. You do not need to include information on people who live with you but are not part of your "household."

2. What is your household's county and state of residence (where you make your permanent home)?

County: _____ State: _____ Do you plan to remain in this county and state? ◯ Yes ◯ No

3. Living Arrangements – Check all boxes that apply to your household.

☐ Own or paying for home ☐ Live in a house provided by someone else ☐ No permanent residence

☐ Live with someone else ☐ Rent house or apartment ☐ Jail

4. List your average monthly household expenses.	
Rent/Mortgage	$
Utilities (gas, water, electric)	$
Phone	$
Transportation (such as gas, car payments, bus)	$
Tax and Insurance on Home Per Year	$
Other:	$
Other:	$
Other:	$

Does anyone pay these household expenses for you? ◯ Yes ◯ No If Yes, who pays? _____

5. Are you or is anyone in your household receiving any of the following? ◯ Yes ◯ No

☐ Temporary Assistance for Needy Families (TANF) ☐ Food Stamps ☐ Medicaid Benefits

If Yes, who? _____

6. Are you or is anyone in your household pregnant? ◯ Yes ◯ No If Yes, who? _____

7. Are you or is anyone in your household disabled? ◯ Yes ◯ No If Yes, who? _____

8. Have you or has anyone in your household applied for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)?

◯ Yes ◯ No If Yes, who applied and when? _____

9. Do you or does anyone in your household have unpaid health care bills from the last three months? ◯ Yes ◯ No

If Yes, which months? _____

10. Do you or does anyone in your household have health care coverage (Medicare, health insurance, Veterans Affairs, Tricare, etc.)?

◯ Yes ◯ No If Yes, who? _____

11. How much money do you have in your wallet, in your home, in bank accounts or other locations? _____

12. How many cars, trucks or other vehicles do you and anyone in your household have? List the year, make and model below. _____

	Year	Make and Model	+
1			−

13. Do you or does anyone in your household own or pay for a home, lot, land or other things? ◯ Yes ◯ No

14. Did you or did anyone in your household sell, trade, or give away any cash or property during the last three months? ◯ Yes ◯ No

15. Have you or has anyone in your household worked in the last three months? ◯ Yes ◯ No If Yes, who? _____

16. List all of your household's income below. Include the following: government checks; money from training or work; money you collect from charging room and board; cash gifts, loans or contributions from parents, relatives, friends and others; sponsor's income; school grants or loans; child support; and unemployment.

Name of Person Receiving Money	Name of Agency, Person or Employer Providing Money	Amount Received	How Often Received?

The statements I have made, including my answers to all questions, are true and correct to the best of my knowledge and belief. I agree to give eligibility staff and the county any information necessary to prove statements about my eligibility. I agree to report any of the following changes within 14 days:

- Income
- Resources
- Number of people who live with me
- Address
- Application for or receipt of SSI, TANF or Medicaid

I have been told and understand that this application will be considered without regard to race, color, religion, creed, national origin, age, sex, disability or political belief; that I may request a review of the decision made on my application or recertification for assistance; and that I may request, orally or in writing, a fair hearing about actions affecting receipt or termination of health care assistance.

I understand that by signing this application, I am giving the county the right to recover the cost of health care services provided by the county from any third party.

I agree to give the county any information it needs to identify and locate all other sources of payment for health care services.

I have been told and understand that my failure to meet the obligations set forth may be considered intentional withholding of information and can result in the recovery of any loss by repayment or by filing civil or criminal charges against me.

Before you sign, be sure each answer is complete and correct. If the applicant is married and the spouse is a household member, the spouse may also sign and date this form, even if the spouse is a disqualified household member.

Signature — Applicant | Date | Signature — Spouse | Date

Signature — Person Helping Complete Form 3604 | Signature — Applicant's Representative | Signature — Witness (if applicant signed with "X")

Address of Person Helping Complete Form 3064 (Street, City, State, ZIP Code): | Area Code and Phone No.:

The County Indigent Health Care Program (CIHCP) helps people pay for needed health care. Whether you can get this help depends on your income, what you own, where you live, other help you receive or could receive and other items. Be sure to:

1. Complete your name and address;
2. Sign and date Page 3 of the application; and
3. Answer as many questions as you can on this application.

Turn in or mail back your application today even if you cannot answer all the questions.

Your Responsibilities

You may be asked to bring proof of what you write on your application or what you tell the person interviewing you. If you need help getting proof, the person interviewing you will help. Examples of some of the items you may be asked to prove and documents you can use for proof are listed below.

Where You Live and Plan to Continue Living – Mail that you received at your address; school records; voting records; property taxes, rent or mortgage receipts; Texas driver license; and other official identification.

What You Own and What it is Worth – Property tax appraisals; estimates from car dealers; ads selling similar items; statements from real estate agents; and bank statements.

Your Income – Paycheck stubs; paychecks; W-2 tax forms or income tax returns; sales records; statements from employers; award letters; legal documents; and statements from persons giving you money.

Other Health Care Coverage – Award or claim letters; insurance policies; court documents; and other legal papers.
Information regarding Social Security numbers should be given if this information is available. Information regarding sex (male/female) is voluntary. This information will not affect your eligibility.

You must give information about health care insurance and any other third party financially liable for health care services paid by the county for yourself and members of your household. By signing and submitting this application, you are agreeing to give the county the right to recover the cost of health care services provided by the county from any third party.

You may be asked to apply for Medicaid, Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI) benefits. If you are asked to apply for one of these programs, or have applied but are waiting for an answer, your CIHCP application may be pended until you are determined ineligible for the other program. If you are not eligible for these other programs and if you have answered all the questions on the application and have given all the proof asked for, your application can be processed. Then, the CIHCP must determine if you are eligible within 14 days.

After turning in your application, you must report within 14 days any changes in your address, income, resources, people living with you, or application for or receipt of Medicaid, TANF or SSI.

INCOME/RESOURCE CHECKLIST Name_____

Have you or any person in the home received or expect to receive money from any of the following sources this month or during the last 2 months? (Please respond to EACH item!)

	Yes	No		Yes	No
Employment or Self-employment			Unemployment Benefits		
Contract Work			Child Support		
Tips or Commission			Alimony		
Workers Compensation Benefits			Interest or Royalties		
Dividends from Stocks, Bonds or Bank Accounts			Money or Royalties from Oil, Gas or Mineral Leases		
Educational Grants, Scholarships or Loans			Money you receive from Rent of Houses or Apartments		
Loans from any other source			Money from Roomers or Boarders		
Cash Gifts or Contributions			Payments from Private Insurance		
Refunds or Lump Sum Payments			Union Benefits (incl. strike benefits)		
Supplemental Security Income (SSI), Disability or Social Security			TANF (AFDC) for women with small children		
Veterans Benefits or Pensions			Military Allotment		
Railroad Retirement or other Pensions			Money from other Public or Private Welfare Agencies		
Babysitting or Cleaning Houses			Flea Markets or Arts & Crafts Sales		
Animal or Pet Breeding and/or Sales			Home Sales: Avon, Mary Kay, Tupperware, Amway, etc.		
Money from Farm (including pasture rental, ASC payments, livestock or other related money)			Misc.: Yard work, Painting, Sale of Cans or Scrap Metal, Woodcutting, Ironing, Sewing, Carpentry, Mechanical Work, Hauling Hay, Fence Building, etc.		
Have you or any person in the home received, or expect to receive income, cash or any other type of assistance from any other source NOT listed above this month or the last 2 months? If Yes, please list source and amount:					
Have you or any person in the home received or expect to receive any assistance from any source in exchange for work instead of receiving money? If Yes, please list source:					
Does anyone help you or any person in the home by paying any of your expenses or any of your bills? If Yes, please list name and relationship to you:					

Do you or any person in the home own, have or are buying any of the following? (Please respond to EACH item!)

	Yes	No		Yes	No
Cars or Trucks			Motorcycles		
Boats, Trailers or other Vehicles			Livestock or Cattle		
Equipment of any kind (such as tools or farm equipment)			Houses, Land or Lots (in Texas or anywhere else)		
Life Insurance			Burial Insurance or Burial Plots		
Rental Property			Checking or Savings Accounts		

	Yes	No		Yes	No
Credit Union Accounts			Individual Retirement Acct. (IRA)		
401 K or Keogh Plans			Money Market Accounts		
Certificates of Deposit (CD's)			Trust Funds		
Pension Funds			Stocks, Bonds or Mutual Funds		
Savings Bonds			Oil or Mineral Rights		
Do you receive Food Stamps?			Have you ever been in the military?		
Do you or any person in the home have any cash, checks or money that is NOT in a bank or credit union? If Yes, how much?					
Have you or any person in the home received any settlement, refunds, or lump sum payments within the last 3 months? If Yes, how much?					
Do you or any person in the home own, have, or are buying anything NOT listed above? If Yes, please list each item and the value:					

MARITAL STATUS: (Check the blank which best fits your circumstance)

_____ I am married to: (Name)_____

_____ I am divorced from: (Name)_____

Date: _____ Place: _____

_____ I am separated from: (Name)_____

His/Her current address: _____

We have been separated since: _____

_____ My spouse is deceased. Date & place of death: _____

_____ I have never been married.

Information about DISABILITY:

Have you ever applied for SSI or SSD? Yes _____ No _____

If Yes, when? _____

Were you denied? Yes _____ No _____ If Yes, when? _____

Do you currently have an application for SSI or SSD on appeal? Yes _____ No _____

**You must provide all information regarding your application denial and/or appeal!

Have you been told by a physician that you were permanently disabled? _____ _____
(12 months or longer) Yes No

THE ANSWERS I HAVE PROVIDED ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ _____ _____ _____
APPLICANT DATE SPOUSE DATE

TEXAS
Health and Human Services

Form 3076
January 2020-E

County Indigent Health Care Program (CIHCP)

Case Record Information Release

Case Record Name:	Case Record No.

I do hereby authorize persons, organizations or establishments having information or records concerning me/us or my/our circumstances, to furnish such information to a representative of the County Indigent Health Care Program. I hereby grant permission for the CIHCP to obtain information which may have a bearing on my/our eligibility for assistance. This release form is valid for six months after the date signed.

Person or Agency to Whom Information will be Released:

☐ Specific Request (Specify in 1 and 2 below.)

1. Information Requested _____

2. Period covered (Dates) _____

☐ General Request (Any information available may be released.)

_____ _____
Signature – Applicant or Recipient Date

_____ _____
Signature – Spouse Date

_____ _____
Signature – Guardian, Power of Attorney, Parent of Minor Child Date

Fraud Policy & Procedures

County Indigent Health Care Program

The following Fraud Policy & Procedures have been adopted for the Hill County Indigent Health Care Program effective September 1, 2016.

General Provisions:

1. Indication of intention to commit fraud in the Hill County Indigent Health Care Program consists of intentionally committing any of the following actions:
    a. Making a false and / or misleading statement.
    b. Misrepresenting, concealing, or withholding facts.
    c. Violating any provision of the CIHCP Act, the CIHCP Regulations or State Statutes relating to the use, or acquisition of CIHCP benefits.
2. Possible Misrepresentations – Situations vary in which an applicant or recipient might intentionally withhold information or present false information to obtain assistance or benefits to which he / she is not entitled. Examples include, but are not limited to:
    a. Information misrepresented or concealed at the time any of the County IHCP forms are completed.
    b. Information misrepresented at the time legal requirements (CIHCP Eligibility) are tested for initial certification or recertification.
    c. Information misrepresented concerning income or resources.
    d. Information misrepresented concerning composition of family group.
    e. Information misrepresented concerning county of residency.
    f. Information misrepresented concerning some element of need.
    g. Information misrepresented to obtain prescribed drugs for purposes other than prescribed intent.
    h. Information misrepresented or concealed concerning incapacity.
    i. Information misrepresented or concealed by a member of the recipient's family, authorized representative or any other individual(s) who assists recipient in obtaining medical services via CIHCP.
    j. Information misrepresented concerning child support payments, including payments being paid in arrears.
    k. Use of fictitious names and / or sources of identification.
    l. Misrepresentation of guardianship or custody of children in the household.
    m. Misrepresentation of dependent status for adults in the household, including, but not limited to, military dependents status and alien sponsorship.
    n. Misrepresentation of employment status.

3. When the Hill County Indigent Health Care Office has reason to believe that a violation may have occurred, the following procedures shall be followed:

    a. CIHCP staff shall investigate all cases of suspected fraud and collect and document evidence.

    b. CIHCP staff will make an initial determination of fraud. The client will be notified by certified letter informing them of the suspension of eligibility and explaining the allegation of fraud.

c. If the client disputes the allegation, the client will be allowed to submit supporting documentation for consideration by the CIHCP staff.

4. After the complete investigation, if the CIHCP staff determines the client committed a violation:

a. The client may be disqualified or suspended from the program as determined by the CIHCP staff.

b. The client shall reimburse the county for all benefits received while they were ineligible.

c. The CIHCP case file may be turned over to local law enforcement for criminal investigation and the client may be subject to criminal prosecution.

d. The client may appeal the CIHCP staff's determination of fraud by following the Hill County Indigent Health Care Program appeal process.

Acknowledgment:

_____ _____

CIHCP Client Signature Date

_____

CIHCP Client Printed Name

Hill County Indigent Health Care

Release of Information to Non-Medical Personnel

Client Name: _____ Case Record #: _____

Information about your County Indigent Health Care Program (CIHCP) case is confidential. In order for Hill County Indigent Health Care staff to speak with a family member or friend regarding your case that individual must be designated below.

Having someone listed below will allow the Hill County Indigent Health Care staff to release and share information regarding your case with/to them to act on your behalf as your authorized representative. **An authorized representative should only be designated for the purposes of translation and/or due to client's physical mobility status.**

- Listing an individual below allows for them to pick up/drop off any required/requested documentation.
- An authorized representative designated for translation purposes is the only individual allowed to receive/make phone calls to the Hill County Indigent Health Care staff on client's behalf.
- All other phone calls made to or received from Hill County Indigent Health Care staff **MUST** be made/received by client if there is no language barrier. An authorized representative is **NOT** to be appointed for verbal communication without a language barrier necessity.
- An authorized representative must provide valid photo I.D., of which a copy will be made and placed in the client's file.

Please print the individual(s) you approve as an Authorized Representative below: Name, Relationship, and phone number.:

Name	Relationship	Phone Number

_____ *I do not wish to designate any representative at this time.*

_____ I understand that it is my responsibility to inform Hill County Indigent Health Care staff in the event I want to change or update who is listed and can act as my Authorized Representative, *changes will only take affect by completing an updated form.*

Client Printed Name: _____

Client Signature: _____

Date: _____